TASK FORCE ON VETERANS' HEALTH SERVICES

REPORT TO THE 122ND LEGISLATURE
FIRST REGULAR SESSION

TO REVIEW AND ASSESS THE NEEDS OF THE STATE'S VETERANS FOR HEALTH CARE SERVICES AND THE AVAILABILITY, ACCESSIBILITY AND QUALITY OF PUBLIC AND PRIVATE HEALTH CARE SERVICES FOR VETERANS

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* While according to statute, Mr. Sims is a member of the Task Force, he served in a different capacity than the other members. Mr. Sims role was specifically to provide the Task Force with information about the VA health care system, and not to make recommendations. Thus the recommendations made by the Task Force in this report are not reflective of any recommendations made by Mr. Sims, who served specifically in an informative capacity.

Executive Summary

The Dirigo Health Reform Act created the Task Force to "review and assess the needs of the State's veterans for health care services and the availability, accessibility and quality of public and private health care services for veterans. Based on its review and assessment, the Task Force shall make recommendations for the reorganization of those services to more effectively meet the needs of the State's veterans for health care services."

In carrying out this charge, the Task Force recognized there is great diversity among Maine's 145,000 veterans, just as there is within the general population. This includes a mix of lower, middle, and upper income veterans; veterans living in both rural and urban areas; and some with access to healthcare from sources other than the Veterans Health Administration (VHA) and some without.

The guiding principles of Task Force have been (a) to increase the range of choices available to veterans without mandating where individuals must receive their care; each veteran will choose the option that will best suit his or her individual needs; and (b) to supply veterans with the best information to make such choices.

The Task Force makes five recommendations:

1) That the VHA conduct a three-year pilot program in Maine to allow private physicians to write prescriptions that can be filled through the VHA formulary for a limited number of veterans living beyond a specified distance from a VHA facility. The Task force proposes (1) that the VHA implement increased cost-sharing for the pilot, so that it is budget-neutral to the Department of Veterans Affairs (VA), (2) an evaluation component to help the VA assess, among other things, whether the pilot can save the VA money by reducing duplication of services, and that the pilot program provides quality of patient care standards equivalent to that provided by the VA through following outcomes based, best practices. It is the VA's decision whether it will run such a pilot.

2) That the State strengthen its ability to inform veterans about available health services by (a) continuing *Operation I Served*, (b) adding information about *Operation I Served* to various Department of Labor (DOL) employment materials (DOL has agreed), (c) adding to the MaineCare application an optional question about veteran status (the State Department of Health and Human Services has agreed); (d) adding to future DirigoChoice applications an optional question about veteran status.

3) That the State continue to ensure coordination and sharing of knowledge regarding veterans health services between the Department of Defense, Veterans and Emergency Management (DVEM), Togus, and Veteran Services Organizations (VSOs). To further strengthen healthcare for veterans, these bodies should communicate with the private medical community via the Maine Hospital Association, Maine Medical Association, Maine Osteopathic Association, and the Maine Academy of Family Physicians, both to inform those organizations of developments in veterans health services and to get those organizations' input on how to continually improve veterans health services.

4) That DVEM issue a report on implementation of the Task Force's recommendations one year from the delivery of this report to the legislature.

5) That Governor Baldacci join all four members of Maine's Congressional delegation in endorsing a Congressional measures to make funding for the VHA "mandatory" funding, and that he encourage the National Governors' Association to endorse the measure.

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Introduction

The men and women who serve in our armed forces leave their homes and families to ensure that the liberties we all enjoy as citizens will be there for those present and in the future. The importance of maintaining a commitment to veterans health coverage is perhaps best summed up by our nation's first president, George Washington, who said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceived the veterans of earlier wars were treated and appreciated by their nation."

Accordingly, the United States has the most comprehensive system of assistance for military veterans of any nation in the world. Over the years and through the multitude of armed conflicts involving the United States, veterans have been promised many benefits for service to their country. In 1776, the Continental Congress recruited men into the military by promising a pension for any disabled soldier. For many years individual states and communities provided direct medical and hospital care for veterans. In 1930, the Veterans Administration was established.[1] The system has grown from 54 hospitals in 1930 to 160 hospitals, 134 nursing homes, 42 residential rehabilitation treatment centers, and 847 ambulatory care and community-based outpatient clinics in FFY2003.[2]

Here in Maine, the Togus VA Medical Center is one of the oldest veterans facilities in the country, having opened in 1866. Togus is a 67-operating bed facility with general medical, surgical, intermediate and mental health beds, as well as a 100-bed Nursing Home consisting of 50 Skilled and Longer Stay beds, and a 50-bed Dementia Unit. The Togus Healthcare System also provides Comprehensive Outpatient Care services through a variety of hospital-based clinics and five Community-Based Outpatient Clinics located in Caribou, Bangor, Calais, Rumford, and Saco.

Today, veterans across our Nation and here in our own State are facing serious, even critical healthcare access issues. Although the State of Maine has served as a model of health care services to veterans with the establishment of remote clinics and other levels of care beyond the one Veterans' Administration hospital in our state, more can be done.

Assessment

Overview and Recent History of the VHA System

The VHA is the largest health care system in the United States, with a FFY2004 budget of $28.4 billion and treating a caseload that is expected to reach approximately 4.7 million veterans in FFY2004 and approximately 4.9 million by the end of FFY2005. Consistent with the growth of hospital outpatient services in the private sector, in recent years, the VHA has increased its emphasis on outpatient care. In FFY2003, VHA spent approximately 50% of its medical care obligations on outpatient care.[3]

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[1] The Veterans Administration (VA) is comprised of the Veterans Healthcare Administration (VHA), which provides health services, and the Veterans Benefits Administration (VBA), which administers a range of other veteran benefits. Both are governed by the Secretary of Veterans' Affairs. The terms VA & VHA are used synonymously throughout this report, as they both refer to the VA System.

[2] Congressional Research Service (CRS) report RL32548, "Veterans' Medical Care Appropriations and Funding Process," by Sidath Viranga Panangala, August 26, 2004.

[3] Numbers in this paragraph are from CRS, *op cit.*.

The VHA is not a health *insurance* program; i.e., it is not a program into which people pay premiums to hedge against the risk of incurring medical expenses, with payments from the program then made to private hospitals and physicians when services are provided. Rather, the VHA is a health care system, with its own hospitals, clinics, and physicians, and, except in limited circumstances, the VHA does not reimburse non-VHA providers for services. In order to receive VHA services, veterans must enroll with the VHA.

A veteran's decision whether or not to enroll in the VHA and use its services, may be based on a range of factors, one of which is whether the veteran has access to health insurance from another source. In 2003, 12% of all non-elderly veterans (under age 65, the age at which federal Medicare coverage begins) were uninsured.[4]

Veterans are more likely to have insurance than the US population in general, due to the fact that the general population includes women and children, who are less likely to have employer-sponsored insurance than are working age males, since the veterans population is 95% male.[5] However, as the cost of health insurance increases and more employers drop coverage, the number of uninsured veterans is likely to increase. In 2003, two thirds of uninsured veterans were employed.[6]

In 2004 slightly less than 1 in 5 (19%) of the nation's 25 million veterans were enrolled with the VHA. Enrollment is likely to increase as the number of uninsured veterans increases. Fifty-nine percent of the veterans served by the VHA are uninsured and thus have no other source of health care services.[7]

The VHA's enrollment system can be explained as follows: "The traditional focus for VA health benefits has been those with service connected injuries or illnesses and those with low income. Based on the extent of service-connected disability (that is, disability resulting from illness or injury incurred or aggravated during military service) and income status, veterans could qualify as eligible for specific categories of coverage, such as inpatient, outpatient, and rehabilitation services. This piecemeal approach was remodeled in the Veterans' Health Care Eligibility Reform Act of 1996, which essentially charged the department with establishing a comprehensive, uniform health benefits package for all enrolled veterans. The act eliminated the distinction between inpatient and outpatient eligibility, mandated an annual enrollment system, and established seven priority classes for enrollment and care delivery."[8]

"Priority groups 1 through 6 represent veterans with service connected disabilities, low incomes, and special categories (e.g., former prisoners of war). Generally, veterans in priority group 7 are not being treated for service connected disabilities and have incomes above the limits needed to qualify for entirely free care. Once enrolled, priority group 7 veterans share equal access with all other priority groups to the healthcare services offered in

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[4] "America's Neglected Veterans: 1.7 Million Who Served Have No Health Coverage," Report of the Harvard/Cambridge Hospital Study Group on Veterans' Health Insurance, October 2004.
[5] Donald Stockford, M.A., Mary E (Beth) Martindale, Dr.P.H., Gregg A. Pane, M.D., M.P.A.; "Uninsured Veterans and the Veterans Health Administration Enrollment System, 2003" Department of Veterans Affairs, April 2002.
[6] Harvard/Cambridge Study Group, *op cit.*
[7] Stockford *et al, op cit.*
[8] National Health Policy Forum (NHPF) Issue Brief No.796, "Veterans' Health Care: Balancing Resources and Responsibilities," Lisa Sprague, April 1, 2004.

VA's Medical Benefits Package including VA supplied prescription drugs and supplies. See Appendix 1 for detail on how each priority groups is defined.

However, priority group 7 veterans currently pay $7 to VA for each 30-day supply of prescription drugs filled, as do veterans who are less than 50 percent service connected and receiving prescriptions for their non-service connected conditions."[9]

"Annually, VA assesses whether it will have the resources to meet the demand for care by veterans in all priorities. If, based on the Secretary's annual enrollment decision, it cannot, then VA may not continue to enroll veterans in the lowest level of priorities."[10]

"In 2002, Congress split Priority Group 7 in two (creating the new 7 and 8), distinguishing between higher- and lower income levels in veterans without service-connected conditions." In early 2003, the VA announced that the department was suspending enrollment for new Priority 8 veterans. "In congressional testimony, [VA Secretary Principi] cited the tremendous growth in the number of veterans seeking VA care, noting that in Priority Groups 7 and 8 alone, the number of patients treated was about 11 times greater than in 1996. Principi explained that his action was necessary in order to maintain the focus on "core" veterans: those with service-connected disabilities, the indigent, and those with special health care needs."[11]

The largest cohort of today's veterans are from the Vietnam era, followed by those from World War II. In a recent Issue Brief on Veterans' Health Care, the National Health Policy Forum wrote that "With the attrition of the World War II generation, the total number of veterans in the population is decreasing. However…the number of veteran patients actually seeking and receiving care from the VA has increased, and this growth is expected to continue. Based on the VA's projection model, without any limitation on enrollment, the number of veterans served is forecast to peak at about 8.9 million enrollees in 2012."[12] Figure 1 shows this phenomenon in Maine.

There are a number of reasons for this increase. One reason is the aging of the veteran population, which the VHA cites as one of the most profound factor affecting veteran trends.[13] "The median age as of September 2003 was 58 years. The number of the oldest old, over 85 years, has more than quadrupled since 1990. VA analysts cite data showing that, on average, their beneficiaries are sicker than other Americans of the same age."[14] As they age, more and more 'near elderly' veterans -- i.e., veterans age 50 - 64 -- may retire early and lose private coverage until age eligible for Medicare, and thus turn to the VHA as their sole source of care.

The high cost of prescription drugs is another likely reason for recent increases in the number of veterans seeking care from the VA. Because of a law allowing the VA to negotiate discounted prices on prescription drugs on behalf of the VA, the Department of Defense, the Public Health Service and the Coast Guard, the VHA is able to offer some of the lowest prices on prescription drugs in the country. Additionally, Medicare will not

[9] VHA web-site.
[10] Stockford *et al, op cit.*
[11] NHPF *op cit.*
[12] NHPF *op cit.*
[13] Stockford *et al, op cit.*
[14] NHPF *op cit.*

provide a drug benefit until 2006, so even those veterans who have Medicare, have often had a need for prescription drug coverage and enroll with the VA to access that benefit.

The number of veterans seeking care will further increase as more veterans return from Iraq, Afghanistan, and other areas of deployment. Here in Maine, over 50% of Army National Guard and Reserve personnel have become combat veterans in the last 24 months, and it is expected that 80% of the National Guard nationwide will be combat veterans by the end of 2006. The active duty mobilizations of whole guard units, such as the 500 member, 133rd Engineer Battalion, will have an impact on future VA health care planning as those units return and increase the veteran population in those communities. The VA is committed to taking care of these newly returning veterans, but the influx of new veterans on the VA health care system will tax the capability of VA to handle both the new veterans and the number of older veterans who are turning to the VA for health care.

The aging of the American Veteran, the increased enrollment of uninsured into the VHA, the increasing cost of providing healthcare, including prescription drugs, and a federal budget environment in which – without changes to the VA's funding mechanism – it appears increasingly likely that VHA funding will not keep pace with costs faced by the VHA, suggests that a 'Perfect Storm' scenario may be brewing for our nation's veterans just at the time when they need the system most.

The VHA in Maine

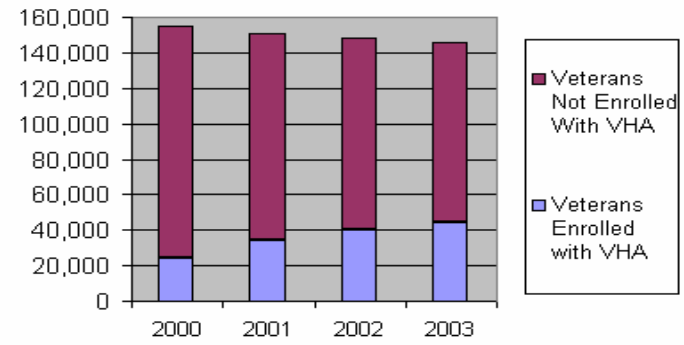
For this reason, it is critical that here in Maine, a state with the one of the nation's highest percentage of veterans (in the 2000 Census, veterans constituted 15.9% of Maine's population age 18 and over, while the average among the 50 states and District of Columbia was 13.5%)[15] and with a population older than the rest of the country,[16] we provide the leadership to a more efficient, more accessible, and more compassionate healthcare system for our national veterans.

Maine has served as a model of health care services to veterans with the establishment of remote clinics. As mentioned earlier, in addition to the hospital and clinics at Togus, the VHA offers Comprehensive Outpatient Care services through Community-Based Outpatient Clinics located in Caribou, Bangor, Calais, Rumford, and Saco.

The VA estimates that there were 145,419 veterans in Maine in 2003.[17] 44,096 (30%) were enrolled with the VHA, up from 16% in 2000 (figure 1). This is a significantly higher proportion than the national proportion of 19%. 34,352 (78% of those enrolled) used VHA services. It is possible that Maine's higher level of enrollment is due to a recent decline in Maine's economy, namely loss of jobs and employer sponsored insurance as a result of manufacturing – a traditional base of Maine's economy – moving oversees. Any further job loss and increase in the cost of health insurance is likely to result in an increase of uninsured among Maine veterans and their enrollment in the VA.

[15] www.va.gov/vetdata/census2000/index.htm
[16] US Census
[17] The source for all enrollment data in this section is Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

Figure 1. Maine Veterans Population and Togus Enrollment, 2000-2003



Source: Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

To investigate which Maine veterans do and do not have VHA coverage, the Task Force obtained county, priority group, and age group specific enrollment data from Togus.

As can be seen in the last column of figure 2, which shows statewide enrollment, there is variation in the percentage of veterans enrolled with the VHA statewide by both age group and priority group. Figure 3 presents the same data graphically. The figures show that:

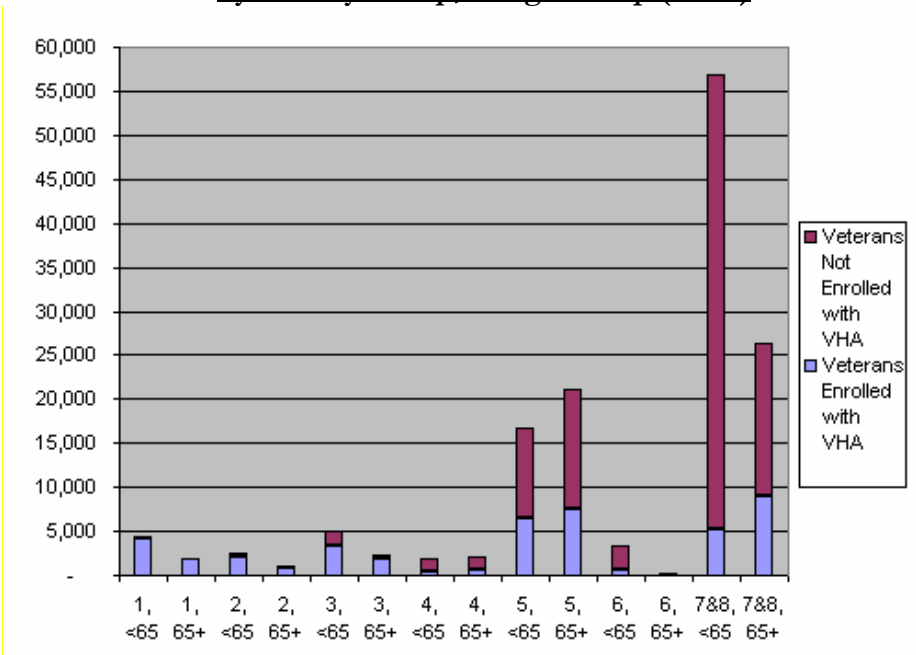
- Veterans in high priority groups (1, 2, and 3) are more likely to be enrolled with the VHA than are veterans in the lower priority groups.
- Priority groups 7 and 8 are the least likely to be enrolled with the VHA. Two likely reasons include that: (a) veterans in priority group 8 have the highest income of all the priority groups and therefore have access to employer-sponsored insurance, and (b) the VA stopped enrolling priority group 8 in January 2003. Togus does not keep data that show how enrollment breaks out between priority groups 7 and 8.
- Veterans age 65 and over are more likely to be enrolled in the VHA than are veterans under age 65. Sixty-five is the age at which people become eligible for the federal Medicare program – the federal insurance program for the elderly, which reimburses private hospitals, physicians, and other providers.
- Slightly more than one-half of the 101,323 non-enrolled veterans are veterans in priority groups 7 & 8 who are under 65 years of age. Veterans in priority groups 7 & 8 who are over 65 years of age make up 17% of non-enrolled veterans. The remaining 32% of non-enrolled veterans are in priority groups 1-6, with the vast majority in priority groups 5.

Figure 2. Maine Veterans Enrolled and Not Enrolled with the VHA, by Priority Group, & Age Group (table)

Priority and Age Group	FY2003 Veterans Population	Veterans Enrolled with VHA	Veterans Not Enrolled with VHA	% of Veterans Ennrolled with VHA
1, <65	4,288	4,195	93	98%
1, 65+	1,897	1,863	34	98%
2, <65	2,407	2,057	350	85%
2, 65+	1,106	923	183	83%
3, <65	5,010	3,393	1,617	68%
3, 65+	2,351	1,860	491	79%
4, <65	1,789	372	1,417	21%
4, 65+	2,138	654	1,484	31%
5, <65	16,654	6,406	10,248	38%
5, 65+	21,045	7,495	13,550	36%
6, <65	3,297	618	2,679	19%
6, 65+	238	119	119	50%
7&8, <65	56,908	5,225	51,683	9%
7&8, 65+	26,291	8,916	17,375	34%
ALL, <65	90,353	22,266	68,087	25%
ALL, 65+	55,066	21,830	33,236	40%
TOTAL	145,419	44,096	101,323	30%

Source: Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

Figure 3. Maine Veterans Enrolled and Not Enrolled with the VHA, by Priority Group, & Age Group (chart)



Source: Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

Figure 4 shows that there is wide variation in participation by county, from a low of 22%, 23%, and 24% in Hancock, Cumberland, and York counties, respectively; to a high of 44% in Aroostook and 39% in Oxford, Piscataquis, and Kennebec counties. Lower enrollment with the VA is somewhat correlated with higher county-per-capita income, which could be interpreted as suggesting that veterans in wealthier counties have access to health care from

other sources and thus do not feel the need to enroll with the VHA. 34% of the state's veterans live in York and Cumberland counties, the two wealthiest counties in the state; an additional 17% live in Penobscot and Kennebec, the counties with the third and fourth highest veterans population; many of the remaining 49% live in highly rural counties. The high enrollment in Kennebec county is likely due to the fact that Togus is in Kennebec.

Figure 4. Veterans Enrolled and Not Enrolled with the VHA, by County

	2003 VHA enrollment	2003 veterans population	% of veterans in county enrolled with VHA	per capita income, 1999*	county enrollment as % of total enrollment	county veterans population as % of state veterans population
ANDROSCOGGIN	3,988	11,577	34%	$ 18,734	9%	8%
AROOSTOOK	3,666	8,275	44%	$ 15,033	8%	6%
CUMBERLAND	6,366	27,291	23%	$ 23,949	14%	19%
FRANKLIN	1,225	3,301	37%	$ 15,796	3%	2%
HANCOCK	1,430	6,447	22%	$ 19,809	3%	4%
KENNEBEC	5,193	13,316	39%	$ 18,520	12%	9%
KNOX	1,358	5,080	27%	$ 19,981	3%	3%
LINCOLN	1,366	4,554	30%	$ 20,760	3%	3%
OXFORD	2,540	6,562	39%	$ 16,945	6%	5%
PENOBSCOT	4,525	15,519	29%	$ 17,801	10%	11%
PISCATAQUIS	914	2,344	39%	$ 14,374	2%	2%
SAGADAHOC	1,265	4,741	27%	$ 20,378	3%	3%
SOMERSET	2,150	5,861	37%	$ 15,474	5%	4%
WALDO	1,209	4,195	29%	$ 17,438	3%	3%
WASHINGTON	1,666	4,398	38%	$ 14,119	4%	3%
YORK	5,235	21,958	24%	$ 21,225	12%	15%
TOTAL	44,096	145,419	30%			

Source: Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.
*Source for per capita income: 2000 US Census

While Togus has data showing that 35% of the patients seen at the VHA have billable insurance,[18] there are no data available on how veterans who do not receive health care services through the VHA otherwise receive care (e.g., through employer-sponsored coverage, Medicare, MaineCare, TriCare, self-pay, or do not receive any care at all).[19] Additionally, there are no data on the extent to which veterans who do receive health care services through the VHA also access health care services from other sources.

However, there is considerable anecdotal evidence that many veterans receive care both from private community physicians as well as from the VHA. This is especially true when veterans wish to avail themselves of the considerable discounts that the VHA is able to offer on prescription drugs. The VHA and Maine's medical community recognize that this system can lead to duplication of services, fragmented care, higher costs, and inconvenience for the veteran.

[18] The VHA keeps such data because, the VHA may bill private insurance companies; it cannot bill Medicare, the federal program for people age 65 and over, or MaineCare, Maine's Medicaid program.
[19] MaineCare is Maine's Medicaid program. TriCare is the healthcare program for active duty and retired service personnel, their eligible family members and survivors.

In an effort to obtain data on the extent of this problem and to help develop possible recommendations to address it, the Task Force developed a survey that was sent to private physicians belonging to the Maine Medical Association or the Maine Osteopathic Association. While the response rate of 7.1% (199 responses of 2800 surveys sent) means that the findings are not statistically significant and thus must be considered anecdotal, responses were instructive. Respondents estimated that just under half of the veterans they see in their practice get prescription drugs through the VHA, and that just over one quarter of the veterans they see in their practice also use the VHA for other health care services.

The VHA's CARES Program and Possible Future Changes in Maine

In May 2004 VA Secretary Anthony Principi announced the final details of a multi-year review of the VHA called "Capital Asset Realignment for Enhanced Services" (CARES). A major focus of CARES was to avoid imbalances in its services in the future, by making sure the size and location of its health care facilities match the needs of veterans. CARES included geographic analysis that included driving distance and waiting time as measures to assess access.

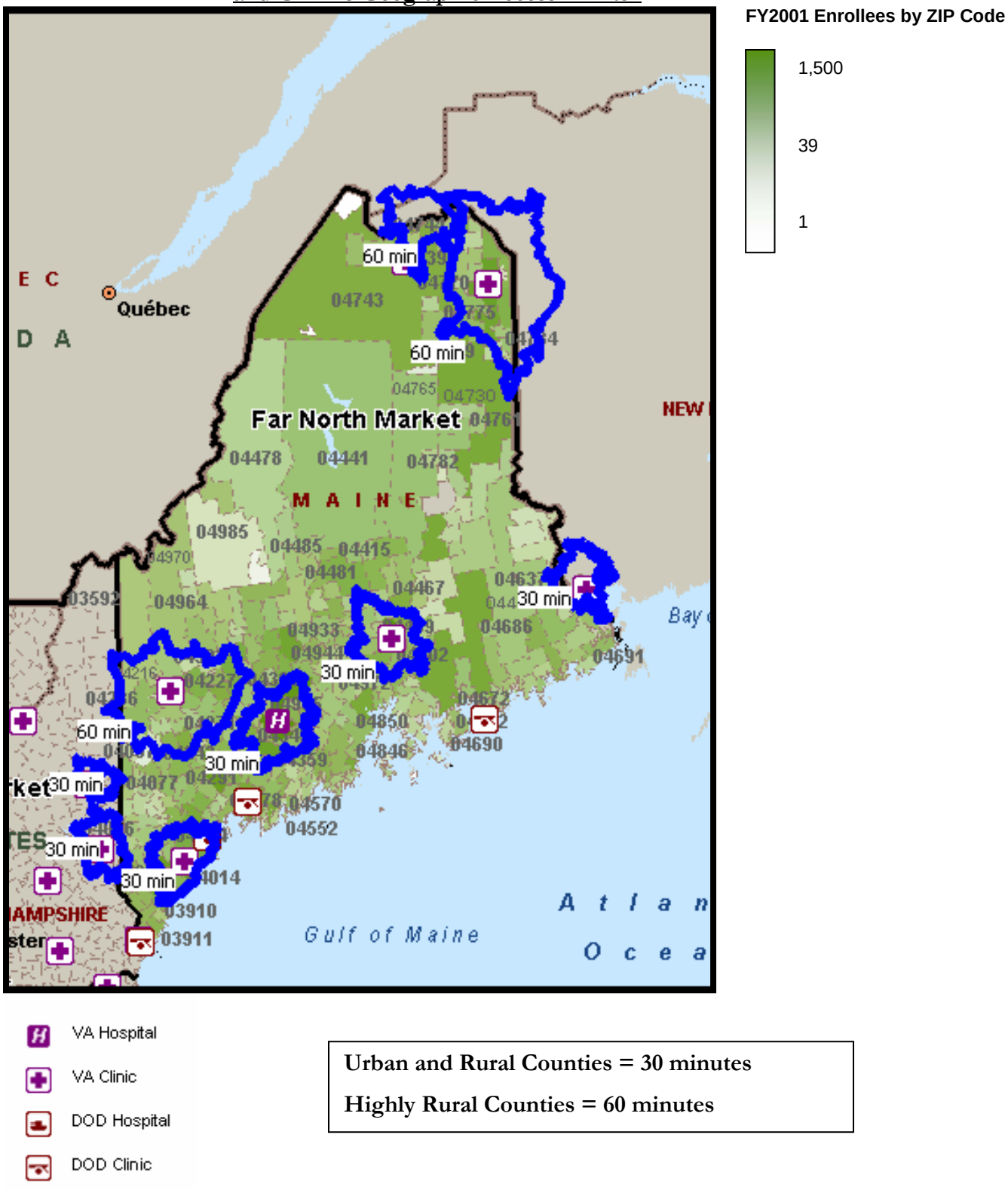
The CARES study found significant access gaps in Maine. The CARES standard for primary care access is that 70% of veterans in urban and rural communities should be within 30 minutes of care (60 minutes in highly rural areas). The study found that only 59% of Maine's veterans are within those guidelines, and that Maine veterans currently travel from 30 to 100 miles to receive VA healthcare (Figure 5 shows a map of VHA facilities, FFY 2001 enrollment by zip code and CARES geographic access limits). The study made a number of recommendations to reduce this distance to an average maximum of 50-60 miles in Maine and 30 miles nationally. Specifically, the VA has announced the following goals in Maine:

- Closing the Access Gap for Primary Care: (1) Adding several VA clinics in rural areas; (2) Adding a new community based outpatient clinic in Cumberland County to meet the needs of veterans who reside between Saco and Togus.
- Closing the Access and Capacity Gap in Inpatient Hospital Care: (1) Contracting for additional hospital beds in Cumberland, Androscoggin, Aroostook, and Penobscot counties; (2) Adding 6 more hospital beds at Togus
- Closing the Capacity Gap in Primary care and Outpatient Mental Health Services: (1) Increased capacity through previously cited outpatient clinics; (2) Enhance existing mental health services at Togus; (3) Contract with mental health providers as needed.
- Closing the Capacity Gap for Outpatient Specialty Care: (1) add specialists to the existing staff at Togus; (2) Use contract specialists within the community; (3) Expand construction of Togus by 70,000 square feet.

Funds for CARES implementation have not been appropriated and will be subject to the annual federal budget process, but implementation of these goals is expected to occur in Maine over the next 7 years.

Implementation of the CARES recommendations will eventually close some – but not all – of the access gaps faced by Maine veterans. Achieving the 70% access standard would still leave about 44,470 of Maine's veterans outside the 60 minute/60 mile travel distance.

Figure 5. Map of VHA Facilities, Enrollment (FFY 2001, by zip code) and CARES Geographic Access Limits*



* This map was created by the CARES Commission in 2003.

Recommendations

The Task Force aimed to come up with recommendations that would

(a) build on CARES;
(b) fit with state and nation-wide developments in the veterans population (aging population, plus younger veterans returning from Iraq and Afghanistan and other areas of deployment) and the healthcare marketplace (increased premiums and cost sharing making healthcare less affordable);
(c) increase the range of choices available to veterans without mandating where individuals must receive their care, and supply veterans with the best information to make such choices; and
(d) takes advantage of technical advances, such as telemedicine, as envisioned in the CARES program.

Recommendation 1. Prescription Drug Pilot

Background. The rising cost of prescription drugs has in recent years become an issue facing people across the nation. With increases in drug prices far outpacing the general rate of inflation, the public has heard repeated stories of senior citizens and others having to choose between food and pharmaceuticals, as drug costs have taken up a greater share of personal income.

As noted earlier, because of a law allowing the VA to negotiate discounted prices on prescription drugs on behalf of the VHA, the Department of Defense, the Public Health Service and the Coast Guard, the VHA is able to obtain the lowest prices on prescription drugs in the country.

In order to access the drug benefit, veterans must enroll with the VHA and receive prescriptions from a VHA physician. Prescriptions that veterans receive from a private physician may not be filled through the VHA. The VA has stated that many veterans are enrolling in the VHA system seeking only pharmacy benefits.[20] In other words, it appears that many veterans who might not otherwise have enrolled with the VHA – veterans who have sufficient means to see a private physician but not necessarily to pay for prescription drugs – enroll to access the drug benefit.

A physician on the Task Force notes that this is especially true for veterans who, upon turning 65, lose their coverage for prescription drugs. They wish to continue ongoing care provided by their family physician, which is covered by Medicare, but prescriptions suddenly cost them hundreds of dollars a month. Many who are veterans qualify for prescription drug coverage through the VHA because of their low income. To access this money saving benefit, they must see a VHA provider at least yearly, either in Togus or one of the outlying clinics. This often involves a wait for an appointment, travel to a distant clinic (see figure 5),

[20] Statement of The Honorable Anthony J. Principi, Secretary of Veterans Affairs, Before The Subcommittee on Health of the Committee on Veterans' Affairs U.S. House of Representatives, March 19, 2003. Additionally, a recent Baltimore Sun article ("VA buys drugs cheaply, many veterans benefit," Cyril T. Zaneski, May 5, 2004) states that "about 20 percent of the veterans who use the VA each year do so solely because of its drug benefits, according to an agency survey, but that nearly 90 percent of the approximately 164,000 veterans who sought enrollment to the VA system last year wanted the drug benefit above all, according to the VA inspector general."

and duplicative health care with several primary care clinicians managing health care for the same patient. If the community physician wants to change a prescribed drug, the veteran must see a VHA physician for approval. This often leads to duplicate lab tests, X-rays, and screening exams, increasing the cost to our health system, fragmenting care, delaying the veteran's obtaining medications, and inconveniencing the veteran, the VHA, and the community physician. The survey of Maine physicians done for this Task Force, found widespread concurrence with this observation.

Although many veterans put up with this cumbersome and fragmented system, a system that allows veterans to obtain primary care health services from their private physicians and prescription drugs through the VHA pharmacy is what many veterans desire.

Accordingly, a number of bills have been introduced in Congress to allow the VHA to fill prescriptions written by community physicians. The VA has opposed these bills for a number of reasons. Two primary reasons are:

- **Cost.** Unlike the federal Medicare program, which automatically receives additional funding when enrollment increases (this is known as "mandatory spending" in federal budget parlance), the VHA receives a fixed budget that is determined each year through the appropriations process. The VA Secretary has pointed out that if Congress expanded the drug benefit without providing additional funds to pay for the expansion, the expansion "would tend to erode the comprehensive medical care benefits that veteran users of the VHA health care system now enjoy"[21] by crowding out spending on core services.
- **VA's Drug Benefit is Part of VA's Coordinated System of Care.** The VA has stated that it "strongly believes that drug therapy must be coordinated, monitored, and managed by a single primary care provider. VHA has maintained control over the cost of its prescription benefit by using sophisticated formulary management techniques and by assuring that prescriptions written by VHA staff are consistent with the formulary management process."[22]

Advocates for these bills have argued that the VA would realize savings from the passage of these bills as a result of a reduction in duplication of services, and that these savings would outweigh any additional costs to the VA. A December 2000 report by the VA Inspector General (IG) estimated the cost of the re-examinations at $1.3 billion in 2001.[23] However, the VA believes that there were significant flaws in the IG's methodology and has indicated that the IG is continuing to examine its methodology. The VA's position is that increase in enrollment would likely outweigh savings from reduction in duplication of services.[24]

Recommendation. With these concerns in mind, the Task Force recommends that the VA conduct a three-year state-wide pilot program in Maine to test the feasibility of allowing a limited number of eligible veterans to obtain prescription drugs from the VA through their

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[21] Principi testimony, *op cit.*
[22] VA Responses to Questions for the Record from Honorable Rob Simmons, Chairman, Subcommittee on Health, Committee on veterans' Affairs, March 19, 2003.
[23] Department of Veterans Affairs, Office of Inspector General, "Audit Of Veterans Health Administration (VHA) Pharmacy Co-Payment Levels And Restrictions On Filling Privately Written Prescriptions For Priority Group 7 Veterans," Report No.: 99-00057-4, Date: December 20, 2000.
[24] Principi testimony, *op cit.*

community physician. The pilot could include an evaluation to help assess whether the pilot might be worthwhile in other rural states.

Under the terms of the proposed pilot, veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to receive VHA pharmacy benefits based on an initial visit with a VHA physician. After the initial visit, a community physician would manage on-going care, including prescriptions. The veteran would enroll with the VHA system and be required to see a VHA physician every three years, rather than annually. Veterans enrolled in this program would pay a higher co-pay – to be established by the VA – and in return have the benefits of maintaining a relationship with their community physician, reducing unnecessary travel and duplication of services.

Specific elements of the proposal:

- **Increased co-payments to ensure cost neutrality to the VA, with all participants subject to co-payments, regardless of priority group.** The Task Force proposes that the VA establish a co-payment system that would enable the VA to fully recapture any additional cost to the VA of increased enrollment and prescription drug expenditures. This could include varying co-payments for specific drugs. The VA could adjust the co-payment schedule annually to account for differences between projected and actual expenditures each year.
- **An enrollment cap set by the VA to limit the size of the pilot, and a program evaluation to assist the VA in monitoring impact of the pilot.** The VA could work with a local organization, such as from the University of Maine system or the University of New England, to design the pilot. This could include establishing an enrollment cap to balance the need to keep the pilot to a limited size while allowing statistically significant analysis, as well as to ensure enrollment of individuals from different parts of the state. The evaluation could answer such questions as:
  - What is the magnitude of savings to the VA from reduction in duplication of services? Does the pilot free up VHA resources for veterans needing core services?
  - What is the demand for the program?
  - How do per-enrollee pharmacy expenditures in the pilot compare to per-enrollee outpatient pharmacy expenditures in the VHA system?
  - What would the cost to the VA have been in the absence of the increased cost-sharing proposed by the pilot? Would those costs have been outweighed by savings from reduction in duplication of services?
  - How does enrollment break out between veterans who had already been driving to VHA facilities for prescription drugs and those who are enrolling with the VHA for the first time? Is there a reduction in the number of veterans who begin using VHA services solely because they want access to the drug benefit?
- **Requiring Participating Veterans to Use a Single Primary Care Physician.** The enrollee must agree to use one primary-care physician, who would coordinate, monitor, and manage the veteran's care for the duration of their participation on the pilot. Any specialist wishing to write a prescription for the participating veteran would need to consult with the primary care physician before writing a prescription. The purpose of

this provision would be to maximize the potential for the effective medication management to ensure cost effectiveness and safe, quality care.

- **The VA would determine which priority groups would be included in the pilot.** The VA might choose to include priority group 8 in the pilot, since there would be no additional cost to the VA.
- **Only veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to participate.**

Potential Benefits of the Pilot Program

- To Everyone:
  - Would free up essential Togus resources as Maine veterans return home from Iraq and Afghanistan and other areas of deployment.
- To Veterans:
  - Easier for veterans to access the lower-priced prescription drugs to which they are entitled, with less delay.
  - Potential to increase the number of veterans willing to enroll with VHA system and benefit from VHA expertise .
  - Continuity of care.
- To Togus and Togus Physicians:
  - Eliminates duplication; increases efficiency; allows Togus to target veterans with specific service-related health issues; reduces waiting lists. This would be good public relations for Togus and could help retention of Togus doctors.
  - Could increase funding for Togus by enrolling veterans who would not otherwise enroll.
- To private physicians:
  - Patients who are veterans can access lower-priced prescription drugs without redundancy of effort.
  - Less red-tape in providing prescriptions to patients who are veterans
  - Continuity of care.
- To the VA, Congress, and the nation's veterans:
  - There has been interest nationwide in somehow expanding the VHA's pharmacy benefit. Maine's serving as a pilot, with a strong evaluation component, could answer essential questions regarding the costs and benefits of such a program. The pilot and study could be used as a basis for estimating the impact of such a program nationwide, or at least in other rural states.
- Other benefits:
  - Fits VA " CARES Program" initiative to provide reasonable access to care
  - Fosters cooperation between State and Federal government.

Recommendation 2. Strengthening the State's Ability to Inform Veterans About Available Health Services

Maine offers a wide variety of benefits to veterans through state, local and federal levels. The eligibility criteria are often different depending on the veteran's service component

(active, national guard and reserve components), the length of service, and the type of discharge they received.

Through the *Operation I Served* initiative, Maine's Department of Defense, Veterans and Emergency Management (DVEM) and the Maine Veterans Coordinating Committee are actively seeking to identify and inform Maine veterans of benefits they may be eligible for as a result of their military service and available resources for accessing them. Appendix 2 provides a letter from Governor Baldacci and Brigadier General John Libby informing Maine Veterans about *Operation I Served.*

Currently, the state has only been able to identify that approximately 50% of its 145,419 veterans have accessed or been advised of benefits and entitlements they might be eligible for as a result of their military service. Given the large veteran population and the geographic challenges faced by being a rural state, there is a need to identify and outreach to the remaining veteran population to ensure that they are provided with information on benefits that they may be eligible to receive.

The following recommendations would provide vital information outreach to Maine's veterans on all benefits and at the same time enhance their ability to receive affordable access to health care services.

- The Task Force recommends to Governor Baldacci, Maine State Legislature, DVEM and the veterans service organizations the continuance of the *Operation I Served* mission.
- The Task Force recommended that Maine's Department of Health and Human Services revise the MaineCare application to add a question about military service. The State Department of Health and Human Services has adopted this recommendation.
- The Task Force recommended that Maine's Department of Labor add information about *Operation I Served* to various employment materials. DOL has agreed to adopt this recommendation.
- The Task Force recommends adding to future DirigoChoice applications an optional question regarding veteran status.

Benefits of this Recommendation

- Increases the range of choices available to veterans without mandating where individuals must receive their care, and supplies veterans with the best information to make such choices .
- Can increase enrollment and funding at Togus.
- Improves access to healthcare to veterans through education on benefits.
- Improves data on veterans.

Recommendation 3. Continuing to Coordinate and Share Knowledge Regarding Veterans Health Services

The Task Force recommends that the State continue to ensure coordination and sharing of knowledge regarding veterans health services between DVEM, Togus, and VSOs. To further strengthen healthcare for veterans, these bodies should communicate with the private medical community via the Maine Hospital Association, Maine Medical Association, Maine Osteopathic Association, and the Maine Academy of Family Physicians, both to inform those

organizations of developments in veterans health services and to get those organizations' input on how to continually improve veterans health services.

As a result of this Task Force, the MMA has begun going to Mini-MAC, a sub committee or Management Advisory Committee from the MAC for Veterans Integrated Service Network (VISN) 1 (the VA regional headquarters in Bedford, MA). Togus's Mini-MAC is made up of members of veterans organizations, congressional representatives, Togus staff, VISN 1 staff, and BVS. They meet quarterly and are updated on ongoing operations of Togus and what is happening in the VISN.

Recommendation 4. Reporting on Implementation

The Task Force recommends that DVEM issue a report on implementation of the Task Force's recommendations one year from the delivery of this report to the legislature. Monitoring implementation will increase likelihood of successful implementation.

Recommendation 5. Urging that the Federal VHA Funding be Changed from "Discretionary" to "Mandatory"

VHA funding is currently "discretionary," which means that funding is voted on by Congress each year. This results in VHA funding being subject to yearly politics of the appropriations process and thus less likely to keep pace with medical inflation and the changing needs of the veterans population.

While the Task Force recognizes that this recommendation falls outside the scope of the Task Force's charge to "make recommendations for the reorganization" of health care services to more effectively meet the needs of the State's veterans, the Task Force notes that the US Congress should act to make funding for the VHA "mandatory" funding, so that – like other veterans benefits – it is not subject to the annual appropriations process. This would ensure that VHA has sufficient funding to meet the needs of veterans across the country. The Task Force notes that all four members of Maine's Congressional delegation, the Maine Veterans' Coordinating Committee, and the Partnership for Veterans Health Care Budget reform – a coalition of nine national Veterans Services Organizations – have endorsed this measure. The Task Force recommends that Governor Baldacci also endorse this measure and that he encourage the National Governor's Association to endorse this measure.

Appendix 1. Priority Groups[25]

The priority groups are as follows, ranging from 1-8 with 1 being the highest priority for enrollment. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans.

As of January 17, 2003, VA is not accepting new Priority Group 8 veterans for enrollment (veterans falling into Priority Groups 8e and 8g.). Please click here for additional information regarding the Enrollment Decision.

Priority Group 1
- Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2
- Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3
- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4
- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5
- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6
- Compensable 0% service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with: exposure to herbicides while serving in Vietnam; or exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or for disorders associated with service in the Gulf War; or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7

[25] From VA web-site at http://www1.va.gov/elig/page.cfm?pg=1

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index

- Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and the HUD geographic index

- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

Additional Information:

The term service-connected means, with respect to a condition or disability, that VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay co-payments to be placed in certain priority groups.

Appendix 2: Operation I-Served Letter

John Elias Baldacci
Governor
State of Maine
207-287-3531

John W. Libby
Brigadier General
Commissioner
207-626-4205

Department of Defense, Veterans and Emergency Management
State House Station 33
Camp Keyes, Augusta, Maine 04333-0033

OPERATION "I SERVED"

TO: All of Maine's Veterans

First, let us say thank you for your service to the State of Maine and the nation. Your service and the service of all of Maine's veterans is greatly appreciated.

Secondly, I would like to explain who a veteran is: A veteran is any one who served on active duty as a member of the Army, Marine Corps, Navy, Air Force, Coast Guard, or a reserve of any of these services or as a member of the National Guard. Also, anyone who served as a Merchant Marine during WW II or as a commissioned officer of the U.S. Health Service, the Environmental Services Administration, or National Oceanic and Atmospheric Administration is considered a veteran. As you can see anyone who wore a military uniform is a veteran.

Operation "I Served" is an outreach to all of Maine's veterans to provide them information on what federal and State benefits they may have earned during their service and is co-sponsored by the Maine Veterans Coordinating Committee and the Bureau of Veterans' Services. Once our veterans have this information, the Bureau of Veterans Services and the Veterans Service Organizations in the State stand ready to assist each veteran in obtaining those benefits they have earned.

If you are a veteran and have not taken advantage of the benefits you have you may have earned please take this opportunity and visit the Bureau of Veterans Services website or call the closest Veterans Advocate to your home. The State of Maine is ready to assist you. Again, thank you for your service.

Sincerely,

John Elias Baldacci
Governor

John W. Libby
Brigadier General

Appendix 3: Sec. G-2 of Dirigo Statute

Sec. G-2. Task Force on Veterans' Health Services.

1. Task force established. The Task Force on Veterans' Health Services, referred to in this section as "the task force," is established and consists of 13 members as follows:

A. One member of the Senate appointed by the President of the Senate;

B. One member of the House of Representatives appointed by the Speaker of the House of the Representatives;

C. Nine members appointed by the Governor:

(1) Three members who are military veterans, including one military veteran representing the Maine Veterans Coordinating Committee, one military veteran representing the Department of Defense, Veterans and Emergency Management Services, Bureau of Maine Veterans' Services and one military veteran representing the Maine Veterans' Homes;

(2) Two members representing state agencies that provide health care services; and

(3) Four members representing health care providers, including one allopathic physician, one osteopathic physician, one representative of hospitals and one provider of mental health services;

D. A representative of the federal Department of Veterans Affairs; and

E. The Director of Maine Veterans' Homes or the director's designee.

2. Chairs. The Senate member and the House member serve as cochairs of the task force.

3. Appointments; convening of task force. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the task force.

4. Duties. The task force shall review and assess the needs of the State's veterans for health care services and the availability, accessibility and quality of public and private health care services for veterans. Based on its review and assessment, the task force shall make recommendations for the reorganization of those services to more effectively meet the needs of the State's veterans for health care services.

5. Staff assistance. The Department of Defense, Veterans and Emergency Management shall provide necessary staffing services to the task force.

6. Compensation. The legislative members of the task force are entitled to the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

7. Report. The task force shall submit a report, no later than January 1, 2005, that includes its findings and recommendations, including suggested legislation, to the joint standing committees of the Legislature having jurisdiction over veterans affairs matters and health and human services matters for consideration in the First Regular Session of the 122nd Legislature.